TAKING THE PAYER SIDE SERIOUSLY:
WHY THE FEDERAL TRADE COMMISSION SHOULD
REDIRECT ITS EFFORTS IN HEALTH CARE ANTITRUST ENFORCEMENT

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Thank you for the opportunity to address the Federal Trade Commission on antitrust issues involving physicians and third party payers. As you know, the American Medical Association is the nation's leading professional organization of physicians. Throughout our 155 year history, our foremost concern has been to safeguard the patient-physician relationship and promote the quality of care. From time to time, this mission has caused us to question specific antitrust enforcement policies that we view as contrary to the best interests of patients. But we place our trust in competition, and we recognize the important role that antitrust has to play in ensuring free markets.

Here, before this Commission, we approach the topic of health care antitrust enforcement with great respect as well as with a set of urgent concerns. To put it bluntly, we believe that federal antitrust agencies have placed physicians under a far higher level of scrutiny than is warranted by our comparative economic strength in today's health care system. By our count, in recent years physicians and physician organizations have been the subject of approximately fifty enforcement actions.[1] Virtually all of the physician organizations involved in these actions have been small in economic and practical terms. The typical Commission

[1] See *FTC Antitrust Actions in Health Care Services and Products* (May 2001), available at www.ftc.gov.

action has involved an IPA, medical staff, or medical society with few assets, a handful of employees or fewer, and limited revenues. It is no wonder that in the last twenty years every one of these organizations has settled with the Commission rather than commit to a time-consuming struggle which likely would have depleted the organization's resources before reaching decision.

By contrast, we are not aware of a single FTC action against a third party payer, ever. The point bears repeating: *To our knowledge, the Commission has never brought a single enforcement action against a health insurance company, HMO, health plan, or other third party payer*.[2] It is also illustrative that none of the nine statements of antitrust enforcement policy in health care issued by the Commission and the Justice Department during the 1990s address any concerns arising from payer market power or conduct.[3] All of the statements are directed at conduct of physicians, hospitals, or other health care professionals and providers.

The absence of enforcement activity on the payer side is puzzling, because there are plenty of reasons to be concerned about the competitiveness of payer markets. In the latter half of the nineties, managed care organizations consolidated at a record pace. Over 350 mergers and acquisitions took place in five years. Today, we are seeing double digit increases in health

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[2] The only possible exceptions are the Commission's actions against health plans controlled by physicians or other health care providers. *See, e.g., RxCare of Tennessee, Inc. et al.*, 121 F.T.C. 762 (1996); *Medical Service Corp. of Spokane County*, 88 F.T.C. 906 (1976). For obvious reasons, however, we think these actions are more properly viewed as actions against providers rather than payers. In addition, as we discuss further below, the Justice Department brought a complaint challenging the national merger of two large payers as it affected two metropolitan markets in Texas. *United States v. Aetna*, No. 3-99CV1398-H (N.D. Tex.) (Complaint filed June 21, 1999; Revised final judgment entered Dec. 8, 1999).

[3] U.S. Dep't of Justice & Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care* (1996).

premiums and in health plan profits. At the same time, consumers have expressed deep dissatisfaction with managed care, and physicians have found themselves vastly overpowered in their dealings with payers.

In any other industry, a merger wave followed by an abrupt rise in prices would cry out for an investigation. But so far, unless we are mistaken, these conditions have simply led to renewed calls by the Commission to "get tough" against physicians and other health care providers.

Something is amiss. Our suggestion today is that the time is ripe for the Commission to consider a fundamental shift in how it deploys its resources within the health care field. Our presentation to another panel of this workshop explains why we believe that the Commission has gone too far in policing physician conduct that poses little or no threat of harm to competition. In this paper, we look at the payer side.

We begin by describing the findings of an AMA study of competition in health insurance. We then examine the recent increases in health plan premiums and profits, and explain why these increases cannot be attributed solely to increases in underlying medical costs. We then discuss why the Commission should be concerned about these facts and view them, at a minimum, as potential indications of a competition problem. Finally, we identify some of the issues that we believe would warrant further investigation, if the Commission were to take a serious look at the payer side.

Consolidation in Payer Markets

The latter half of the 1990s was a period of unprecedented consolidation among health insurance companies. Between 1995 and 2000, there were over 350 mergers involving

health insurers and managed care organizations.[4] Between 1994 and 1999, mergers and acquisitions of managed care and benefit companies affected over 130 million Americans.[5] Today, over 50% of commercially insured persons are covered by one of the ten largest national health plans.[6]

But the effects of consolidation are most clearly seen at the local and regional levels. Last year, the AMA did a comprehensive study of competition in health insurance.[7] Working with internal and outside experts in health economics and policy, we looked at payer market share information for 40 large metropolitan statistical areas ("MSAs"). We also looked at state level measures of insurer markets, including 19 less populated states where MSA-level data was not available. The geographic extent of our analysis were dictated by the available data. We surveyed the most reliable data sources on HMO and PPO enrollment, reconciled the different sources, and eliminated "double counting." Our study represents the most extensive effort ever undertaken to paint an accurate picture of the payer market.

The study confirmed what patients and physicians and employers around the country already knew: In many parts of the country, health insurance markets are dominated by a few companies that have significant power over the market. In other words, these payers may

[4] Levin Associates, *The Health Care Acquisition Report* (8th ed. 2002).

[5] June 23, 1999 Press Release from Levin Associates, *Managed Care Consolidation Affecting More than 50% of the U.S. Population*.

[6] Kaiser Family Foundation, *Trends and Indicators in the Changing Health Care Marketplace* (May 2002), at 58.

[7] *See* American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets* (2001); Figures 1-3 (attached).

have the ability to profitably raise premiums to employers without losing market share, and to profitably depress physician payments without losing their physicians.

In our study, we looked at payer markets in three ways: First, we included only HMOs (as the Justice Department did in its challenge to the Aetna/Prudential merger in Texas); second, we included only PPOs; and, third, we included both HMOs and PPOs. Next, we calculated the Herfindahl-Hirschman Indices ("HHI") for each market area and – applying the *Merger Guidelines* – classified each market as "unconcentrated," "concentrated," or "highly concentrated."[8]

What did we find? For the 40 large MSAs with populations over one million, 69.8% of the HMO markets were highly concentrated; 87.5% of the PPO markets were highly concentrated; and 47.5% of the combined HMO/PPO markets were highly concentrated. Moreover, in 48% of these highly concentrated MSA markets, a single payer had a market share in excess of 40 percent. And in 24% of these markets, a single payer had a market share in excess of 50%.

The situation was even worse in the 19 states where no MSA level data was available. The HMO market in 100% of these states was highly concentrated. The PPO market was highly concentrated in 89%. And, even using the broad definition of a combined HMO/PPO market, 84% of these markets were highly concentrated. Further, in 76% of these 19 less populated states, a single payer had a market share in excess of 40%. In 56% of these states, a

[8] U.S. Dep't of Justice & Federal Trade Commission, *Horizontal Merger Guidelines* (1992; revised 1997) ("*Merger Guidelines*"). Under the *Merger Guidelines*, markets with an HHI below 1000 are considered unconcentrated; markets with an HHI between 1000 and 1800 are considered moderately concentrated; and markets with an HHI above 1800 are considered highly concentrated.

single payer had a market share in excess of 50%. And in 31% of these states, a single payer had a market share in excess of 70% -- a dominating share by any measure.[9]

We recognized that market concentration is not the only measure by which the competitiveness of payer markets is assessed. So we also looked at other characteristics of these markets. In doing so, we found further cause for concern. Payer markets are characterized by significant regulatory barriers to entry. To enter a market, a payer must invest millions of dollars to comply with state regulations governing insurance companies. The payer must also invest time, labor, and money to establish relationships with physicians and other providers in the market. In its challenge to the Aetna/Prudential merger in Texas (the only health plan merger ever challenged by either federal antitrust agency), the Department of Justice noted that "effective new entry for an HMO or HMO/POS plan in Houston or Dallas typically takes two to three years and costs approximately $50,000,000."[10]

The costs and regulatory hurdles facing a new entrant make it possible for a payer with a large market share to increase premiums without concern that it will lose market share. Even worse, large payers may use contractual devices such as "most-favored nation" clauses or "all-product" clauses to lock in physicians and keep out new rivals. The large companies are clearly in the driver's seat.

[9] Because this potion of our market analysis was done on a state-wide basis, these market share estimates may significantly understate the market power of some payers in some local markets.

[10] *United States v. Aetna,* No. 3-99CV1398-H (N.D. Tex.) (Revised Competitive Impact Statement filed August 3, 1999).

On the supply side, physicians face unique legal and ethical responsibilities that enhance the ability of payers to exercise market power.[11] In most areas of the economy, it is taken as a given that if a customer does not pay in a timely fashion, the supplier will cease providing goods or services. This is not the case in medicine. Instead of switching customers rapidly in response to changes in price, physicians' decisions are driven by their relationships with patients. Further, many smaller physician practices simply lack the resources to invest in information systems that would enable them to track a payer's performance in paying bills promptly and accurately. And most physicians are in small practices: More than half of all self-employed physicians practice in a group that has fewer than 5 physicians; for physicians who practice in physician-owned groups, more than half practice in a group with fewer than 10 physicians.[12]

The combined effect of these conditions is to enable an insurer with a large market share to increase its premiums while also reducing physician payments. Consider, for example, the California situation: As of 2000, five health plans in California accounted for 90% of HMO patients and three plans represented 67% of all patients.[13] These plans wield enormous bargaining power, driving payment rates well below the level needed to provide medically

[11] *See* Herndon, "Health Insurer Monopsony Power: The All-Or-None Model," 21 *Journal of Health Economics* 197-206 (2002).

[12] See Figure 4 (attached), "Distribution of Self-Employed Physicians and Physicians Employed in Physician Owned Groups by Practice Size, 1999."

[13] *See* Bodenheimer, "California's Beleaguered Physician Groups – Will They Survive?" 342 *New England Journal of Medicine* 1064 (April 6, 2000).

necessary care and forcing dozens of medical groups and IPAs into bankruptcy.[14] From the consumer's perspective, the result has been chaos – higher out-of-pocket costs, longer waiting times, and reduced access to the patient's physician or to any physician at all. Worse still, these conditions have driven a wedge between physicians and their patients, and contributed to an atmosphere of distrust and acrimony among patients, payers, and physicians.

Rising Health Premiums

If the late '90s were a period of mergers and acquisitions in managed care, the years since have been characterized by increasing health plan premiums and profits. Again, let's take a look at the facts: From 2000 to 2001, premiums for employment-based insurance policies increased by 11%.[15] Premium increases outpaced overall inflation of 3.3% by a wide margin.[16] From 2001 to 2002, premiums increased by 12.7%, the highest rate of increase since 1993.[17] The increase marked the sixth consecutive year of accelerating premium increases.[18]

Families were particularly hard hit by HMO premium increases in 2000. From January of 2000 to January of 2001, the average national premium for traditional HMO family

[14] Robinson, "Physician Organization in California: Crisis and Opportunity," *Health Affairs* (July/August 2001), at 85 ("Low payments, expressed most clearly in dismal per member per month capitation rates, are the proximate cause of the difficulties inflicting medical groups and IPAs in California."); Lentz, "Closure Count: Report Enumerates California Medical Group Failures," *Modern Physician* (Aug. 1, 2001).

[15] Strunk, et al, "Tracking Health Care Costs," *Health Affairs* (Sept. 26, 2001), at W45.

[16] Jon Gabel, et al, "Job-Based Health Insurance in 2001: Inflation Hits Double Digits, Managed Care Retreats," *Health Affairs* (Sept./Oct. 2001), at 180.

[17] See Figure 5 (attached), "Increase in Health Insurance Premiums Compared to Other Indicators (1988-2002)."

[18] Id.

coverage increased 13.2%, rising from $493 to $558.[19] During that same period, the average national premium for traditional HMO single coverage increased 11.9%, from $168 to $188.[20]

All indications are that premium increases will continue for the near future. Preliminary results of a recent survey indicate that HMOs expect to implement double-digit premium increases into 2003. In a survey of one hundred HMOs serving the employer market, over 70% of the HMOs expected to push through premium increases greater than 15%.[21] The national average increase expected by the 100 HMOs participating in the survey was 17%.

The recent premium increases have not been driven solely, or even primarily, by increases in underlying medical costs. Private health insurance administrative costs (which include profits) rose steadily, from $208 per person in 1997 to $270 per person in 2000.[22] Data also indicate that premiums have been rising at a substantially faster rate than claims expenses. Although expected claims expenses rose 9.5% in 2001, premiums increased 12.3 percent for fully insured plans.[23] Further, recent reports on payer profits refute any notion that claims expenses are driving premium increases. Profit margins of the major national payers have been steadily rising. Despite a slowdown in the general economy, in the first half of 2001 the

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[19] October 31, 2001 Press Release from InterStudy Publications, *HMO Enrollment Concentrated in National Firms*, at 9.

[20] Id.

[21] July 2, 2002 Press Release from Milliman USA Consultants and Actuaries, *2003 HMO Rates to Increase an Average of 17%*.

[22] Kaiser Family Foundation, *supra* n. 6, at 73.

[23] "For self-insured firms, changes in premium equivalents are a proxy for trends in expected claims expenses. Premium equivalents rose 9.5 percent in 2001 . . . Premiums increased 12.3 percent for fully insured plans, which indicates that insurers are raising their prices faster than claims expenses are growing." Gabel, *supra* n. 16, at 181-82.

managed care industry posted a 16% increase over its profits for the first half of 2000.[24] This trend continued through last year and into this year. HMOs and health insurers reported a 25 percent increase in profits for 2001, rising from $3.3 billion in 2000 to $4.1 billion in 2001.[25] In the second quarter of 2002, UnitedHealth, Aetna Inc., Humana Inc., and WellPoint Health Networks Inc. all posted higher profits.[26] Aetna's quarterly earnings rose more than ten-fold, from profits of 7 cents a share in the second quarter of 2001 to 70 cents a share in the second quarter of 2002.[27]

According to financial analysts, the increases in managed care profits are the result of three things: premium increases, plan mergers, and withdrawals from unprofitable markets.[28] As one analyst put it, "there's very little pricing competition for employers right now and that allows HMOs to get the premiums they need to see to be profitable."[29] Another analyst explained the industry's profits as follows: "What's driving it is very simple: We finally have

[24] These statistics are from Weiss Ratings Inc., an independent ratings agency. *See* Jacob, "HMO profits rose overall last year: Higher premiums and exits from unprofitable markets helped improve insurers' bottom line," amednews.com (March 4, 2002). *See also* October 31, 2001 Press Release from InterStudy Publications, at 6.

[25] September 3, 2002 Press Release from Weiss Ratings, Inc., *HMOs' and Health Insurers' Profits Increase 25% to $4.1 Billion in 2001*.

[26] Dixon, Chicago Reuters, *Cigna Profit Down on Investment Losses* (Aug. 2, 2002).

[27] Dixon, Chicago Reuters, *Aetna Posts Higher Profits; Ups Outlook* (Aug. 1, 2002).

[28] *See generally* Wholey, et al, "The effect of market structure on HMO Premiums," 14 *Journal of Health Economics* 81-105 (1995).

[29] Brent Layton, of consulting firm Layton & Associates, quoted in Bryant, "HMO profits rise in first quarter," *Atlanta Business Chronicle* (May 31, 2002).

premium increases outpacing medical inflation."[30] Wall Street certainly does not view the premium increases as a mere pass through of costs.

The companies and their top management have been richly rewarded for these results. As of August 15, while the Dow Jones Industrial Average was off 12% from the start of the year and the Standard & Poor's 500 Index was down 19%, stocks of eight of the largest managed care companies were up an average of 19%.[31] Meanwhile, in 2001, the CEOs of at least 14 managed care companies all received salaries and bonuses in excess of $1 million – in some cases quite a bit more.[32] And that's not counting stock options.

To the extent that premium increases are attributable to rising costs of health products or services, physician costs have not been one of the major drivers.[33] In the early to mid-90s, growth in spending for physician services decreased, from 5.4% in 1991 to 1.6% in 1996. After years of reductions in physician payment rates from private insurers, physician payments started to increase in 1997. The increase in physician payment rates leveled off in

[30] Joel Ray, an analyst with Wheat First Union in Richmond, Va., quoted in New York Associated Press, "HMOs profiting from higher premiums" (Feb. 26, 1999); *see also* Jacob, "HMO profits rose overall last year: Higher premiums and exits from unprofitable markets helped improve insurers' bottom line," amednews.com (March 4, 2002).

[31] "Managed care's profits come from physician pockets: HMO stocks are going up in a down market, and doctors appear to be paying the price," amednews.com (Sept. 2, 2002).

[32] "CEO Bonuses Tied to Performance," *Managed Care Week* (May 6, 2002). The fourteen companies are WellPoint, United, CIGNA, Anthem, Oxford, Sierra, Aetna, Coventry, First Health, Trigon, Humana, Mid-Atlantic, Amerigroup, and PacifiCare.

[33] See Figure 6 (attached), "Annual Percentage Change in National Spending for Selected Health Services 1998-2002, Office of the Actuary, Centers for Medicare and Medicaid Services."

2000.[34] However you cut the pie, physician costs today are simply not a significant factor driving growth in overall healthcare costs.

Effects of Reduced Competition in the Health Insurance Sector

Why is it, then, that the Commission continues to focus on physicians rather than payers? Is there something about physician markets that justifies the Commission's extraordinary vigilance in policing them? Alternatively, is there something about payer markets that counsels in favor of a hands-off attitude?

One perspective holds that payers are simply purchasers of health care services, whose interests are closely aligned with consumers. (The "consumer" in most health care transactions includes both the patient and an employer, who together bear most of the cost of health premiums and medical services). Under this view, when payers prevail in fee negotiations, the ultimate winner is the consumer.

This view is terribly naïve. First, consumers don't buy the idea that their interests are aligned with those of their health plan – witness the "managed care backlash" of recent years. Patients of course share their health plan's interest in avoiding unnecessary expenses. Indeed, patients bear a significant percentage of overall health care costs, particularly in the physician sector, and that percentage is expected to grow in the next few years.[35] But patients also have an intense interest in receiving high quality medical care – an interest that their health plans do not necessarily share. Judge Richard Posner, a leading antitrust jurist and scholar, put the point this

[34] Strunk, *supra* n. 15, at W41-W42.

[35] *See* Gabel, *supra* n. 16, at 182; Levit, et al, "Inflation Spurs Health Spending in 2000," *Health Affairs* (Jan./Feb. 2002), at 178.

way: "the HMO's incentive is to keep you healthy if it can but if you get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and cheaply as possible."[36] Whatever else one may say about this observation, it would seem to reflect at a minimum the understanding of one particularly sophisticated consumer that his interests are not aligned with those of payers.

Second, a perspective that equates the interests of the payer with those of consumers is misinformed because payers are not merely purchasers; they are also sellers. Employers who negotiate group health premiums with their health insurers know this fact all too well. Payers do not simply pass through expenses that originate with physicians and other health care providers. Premiums reflect administrative expenses and profit, not just claims expenses. Competition in the health insurance sector therefore matters.

Indeed, competition matters *especially* in the health insurance sector. When health premiums rise due to a lack of competition, some employers will cease providing coverage or will reduce the scope of benefits provided. Lack of coverage for uninsured and underinsured individuals places enormous pressures on other segments of the health care system – particularly physicians and hospitals. It also leads to otherwise avoidable expenditures for emergency treatment and medical services that could have been prevented. Competition among health insurers helps to avoid these results.

Further, as the Justice Department recognized in the *Aetna* matter, a lack of competition among health insurers may also lead to anticompetitive effects on the supply side. A

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[36] *Marshfield Clinic v. Blue Cross & Blue Shield United of Wisconsin*, 65 F.3d 1406, 1410 (7th Cir. 1995).

dominant payer can exercise monopsony power by driving physician fees down below the competitive level. Such fee reductions can lead to reduced hours, departures from the market, and reduced access to care for patients. Indeed, these are precisely the effects that are currently being observed in a number of markets that are dominated by large payers.

In short, the Commission should care about competition in the health insurance sector for all the same reasons that it cares about competition in other sectors of the economy – and more. There is no justification for a one-sided enforcement policy that puts the sole burden of compliance on physicians.

Issues for Further Study

If the Commission were to take a serious look at payer market power and conduct, there would be no shortage of important issues to address. Here are some of the issues that we think merit particular attention:

1. *Impact of Consolidation*. Have mergers among managed care companies yielded the efficiencies that were claimed by those companies at the time of the merger? To what extent have the previously separate companies been integrated into a single firm? Do employers view the mergers as, on balance, helpful or harmful to competition? What impact have the mergers had on premium and benefit levels? To what extent have they resulted in higher numbers of uninsured persons or reduced benefit levels for the insured?

2. *Monopsony Power*. What is the effect of dominant payers on the availability and quality of physician services? To what extent have reduced fees resulted in physician departures from markets? To what extent has the quality of care been affected?

3. *Payer Joint Ventures.* In recent years, payers have engaged in a variety of joint ventures. Have these ventures involved any inappropriate information exchanges? Have they resulted in the development of any new products or services?

4. *Coordinated effects.* To what extent have payers engaged in coordinated conduct that has harmed competition – for example, coordinated premium increases, joint reductions in fees, or simultaneous departures from a market? Has such conduct resulted from agreements, or simply from payers observing the conduct of their competitors and mimicking it?

5. *Abusive Contract Provisions and Payment Practices.* To what extent has market power enabled payers to impose abusive contract provisions and payment practices on physicians? The Commission should consider the impact of such practices as the following:

- *"All products" clauses.* What is the impact of "all products" clauses? Such clauses require physicians to participate in a less attractive health plan as a condition of participating in a more attractive plan. Do such clauses represent "tying"? As a factual matter, do they tend to result in an increase or a decrease in physician participation in health plans?

- *"Most-favored nation" clauses.* What is the impact on competition of a "most-favored nation" clause requiring physicians to give a dominant payer the benefit of the physicians' most favorable discount to any payer? In what circumstances do such clauses harm competition?

- *Undisclosed fee schedules.* Many payer contracts provide that the payer will not disclose its fee schedule. Without access to payers' fee schedules, physicians are unable to determine whether payers are making payment errors or to engage in budgeting for their practices. What is the effect on competition of contractual provisions that limit the ability of physicians to hold payers accountable for paying fees accurately?

- *Unilateral amendment by payer.* Many contracts allow payers to change not only physician fee schedules but also contract terms that govern whether and under what circumstances patients are able to obtain medically necessary services. What does the acceptance of such provisions reflect about the state of competition in the market?

- *Slow Pay*. Payers often do not reimburse physicians in accordance with their contractual and other legal requirements, yet physicians often have no cost-effective recourse available. Slow pay problems may result from coordination of benefits issues, requests for additional documentation from physicians, improper denials, and other reasons. What do these practices reflect about the state of competition in the market and when do they themselves rise to the level of an anticompetitive practice?

- *Restrictive Definitions of Medical Necessity.* Many payer contracts include overly restrictive definitions of medical necessity that prevent physicians from recommending proven treatments. What do these provisions reflect about the interests of payers in relation to the interests of patients? Do these provisions discourage innovation in the market?

- *Indemnification Clauses for Patient Privacy Violations*. Many payer contracts require physicians to provide confidential patient information to the payer for utilization management and other purposes. These contracts frequently require the physicians to indemnify the payer for legal claims brought against the payer for the payer's misuse of that information. What does the assumption of liability by physicians for improper conduct by payers reflect about the state of competition in the market?

6. *Payer Complaints.* How much weight should the Commission give to payer complaints about physician conduct? Do payers represent an unbiased source of information about the market? What other sources should the Commission consider? Does the Commission give appropriate weight to the views of physician groups when attempting to assess the various competitive forces at work in a market?

7. *Views of Patients.* The Commission should consider how best to obtain information on patient satisfaction and to factor this consideration into its analysis of the market. A recent survey shows that approximately half of privately insured American adults under age 65 report problems with their health plans, including denials or delays of coverage or care.[37] These and other issues should be further explored. Do patients understand the explanation of benefits

[37] Kaiser Family Foundation, *supra* n. 6, at 81.

provided to them by their payers? Are patients paying the correct amount for deductibles and copayments? Are patients satisfied with their access to physician services?

Conclusion

In closing, the Commission and its staff have often observed that health care represents a critical component of our nation's economy. We agree with that assessment. We believe, however, that the Commission has spent too much of its time tracking down physician groups, while looking the other way when payers engage in activities that have real and widespread effects on the cost and quality of patient care. We respectfully ask that the Commission reconsider its approach, and take a serious look at competition on the payer side. And we thank you for the opportunity to participate in these proceedings.